California Foundation for
Independent Living Centers

Executive Summary

2006 Pilot Survey of Disability
Access Services Provided
by California Health Plans

California Foundation for Independent Living Centers

1029 J Street, Suite 120
Sacramento, CA 95814
Tel (916) 325-1690
Fax (916) 325-1699
TDD (916) 325-1695
www.cfilc.org

Disability Health Access
Phone 415-239-9100
Fax 415-239-9106

Disclaimer

The Information contained in this report is for the purpose of reporting to the Office of the Patient Advocate (OPA) results and recommendations of the 2006 Pilot Survey of Disability Access Services Provided by California Health Plans.

The report is part of a consulting contract OPA has with The California Foundation for Independent Living Centers (CFILC).

CFLIC has a contract with OPA to provide technical assistance to the Office and its contractors in the development consumer education programs and materials that are targeted and accessible to enrollees with disabilities, and to assist in the development of a pilot survey of health plans. Disability Health Access was contracted by CFILC to assist with the development, distribution and analysis of the pilot survey.

This opinions expressed in this report do not necessarily reflect the opinions of OPA or and the recommendations contained in this report should not be interpreted as OPA's policy approach for assessing health care access and quality for this population.

People with disabilities are not only a significant proportion of any health plan's patient population but constitute a potential growth area for health plan market share. Over 54 million Americans have disabilities. One in five people live with at least one disability. With the aging of the baby boomer population, the number and proportion of people with disabilities will increase. Most Americans will experience a disability at some time during their lives. In addition, over 25 million family members provide personal assistance and care. Because of their affiliation with health plan members with disabilities, many of them could potentially become members.

The Office of the Patient Advocate (OPA) is charged with providing consumer education to HMO enrollees and to develop written materials to assist consumers with navigating the managed care system. Additionally, OPA is charged with producing an annual Report Card. The HMO Report Card provides consumers, purchasers, advocates, and regulators with comparative information on the performance of California HMOs and medical groups using clinical and member/patient satisfaction data. Health Plans participate in the HMO Report Card process voluntarily. The HMO Report Card provides health plans with an opportunity to show their commitment to help patients make informed choices about their health care and the health plan that best fits their needs.

Recognizing the tremendous impact the delivery of health care services has on the lives of people with disabilities, OPA examined health care service delivery for these consumers.

Survey Development Process and Timeline

September / October 2005: OPA convened a technical work group to provide the office with review and advice on a draft survey that had been prepared by OPA with input from The Center for Disability Issues in the Health Profession (CDIHP) and revised by Anne Cohen project consultant. The work group included representatives from health plans and consumer advocacy groups who have expertise in providing access to health care services for persons with disabilities. OPA used the feedback from this meeting to revise the draft survey form.

November 2005: OPA convened a public meeting to obtain input from stakeholders and the general public about the survey form and project. Feedback received from the public meeting provided the basis for finalizing the survey content and approach.

December 2005: OPA pilot tested the survey form with a small sample of health plans and made final adjustments to the form to ensure that the survey questions were clear and understood by health plan respondents.

January 2006: The final survey was made available via an online survey tool to 28 commercial and Medi-Cal health plans on January 11th 2006 and were given until

February 7th to respond. OPA conducted two training sessions on January 19th and 24th for health plan staff that were responsible for completing the survey.

February 2006: The Project consultant conducted analysis of reported data.

March 2006: OPA reconvened the technical work group to review survey results and advise project consultants on the development of a final report.

March 2006: The project consultant submitted a final report and recommendations to OPA.

Acknowledgements

Objectives of the Survey project

The objectives of the survey were:

1. To determine the feasibility of a survey approach to describe and measure services health plans provide enrollees with disabilities.

2. To collect baseline data on health plans' disability services.

3. To use survey data to establish and evaluate OPA program initiatives targeted to enrollees with disabilities

Survey Design

The survey consisted of twenty-seven (27) questions regarding the extent to which health plans:

1. track enrollees disability-related access needs
2. provide materials in alternative formats
3. offer information regarding the physical accessibility of providers' offices
4. provide or assist enrollees with transportation to medical visits, and
5. make their web sites accessible to enrollees with disabilities.

Survey Submission

To improve the process by which plans report data, OPA utilized an online reporting system called Zoomerang (see http://www.zoomerang.com). The online survey was submitted to twenty eight (28) health plans on January 11, 2006, with the deadline for submitting responses on February 7, 2006. Utilizing an online survey greatly improved the efficiency of data analysis. However, the online system presented several challenges including:
- limitations in the visual layout for multi-part questions
- limitations in the ability to navigate the questions
- limitations in the ability to print responses when submitted
- limited space to make comments
- limitations in changing responses once submitted.

OPA hoped that the survey results would provide the basis for future program initiatives, including targeted consumer education programs and service assessments on the HMO Report Card. Unfortunately, of the twenty-eight (28) health plans asked to participate in the project, only ten (10) submitted surveys, a response rate of thirty-six percent (36%). In addition, because of concerns over question design, some plans did not complete the survey. Because of the low response rate, it is difficult to evaluate the degree to which California Health Plans as a whole provide disability accessible services.

Follow-up contacts sought to determine why most plans did not respond to the survey. Of the eighteen (18) plans that had not responded to the survey, eight (8) gave specific reasons:

- One (1) indicated that key Plan individuals responsible for filling-out the survey were on medical leave.

- Two (2) Plans were applying for special needs plans as part of Medicare Part D applications and indicated they did not have the staff resources to complete the survey.

- One (1) Plan indicated their resources would be better used elsewhere given the Plan's size in the California market.

- Despite OPA's assurance that it would not publicly report individual Plan responses, one (1) Plan cited concern over how the data would be used.

- Three (3) Plans were in the process of evaluating the accessibility of their services and did not feel it was appropriate for them to participate in the survey. In relation to this issue, one (1) of those plans had concerns that the yes/no question format did not reflect the process plans undertake to serve the senior and disabled population better. The Plan suggested a graduated answer format such as:

  - We are considering
  - We are in the process of implementing
  - We have in place
  - Not applicable

  One (1) of these Plans also had additional concerns about potential ADA lawsuits as a result of responding to the survey.

Summary of Results

Identification of Member Needs (Questions 4-8)

A critical component of promoting access to health care services is informing individuals that they have the right to request disability-related accommodations and that health care entities have procedures to follow-up on those requests. Questions asked about Plans' policies, procedures, and training to provide that information and establish those processes. Some of the results included:

- Over sixty-two percent (62%) of all responding Plans across all product lines have a specific individual, department, interdepartmental team, or program to develop and oversee services for people with disabilities.

- Over seventy percent (70%) of all responding Plans across all product lines have a process to inform members with disabilities of their right to disability accommodations.

- Sixty-five percent (65%) of all responding Plans across all product lines provide training to Plan Member Services Staff regarding members' right to request disability accommodations.

- Over forty-seven percent (47%) of all responding Plans across all product lines provide training to providers and office staff regarding the members' right to request disability accommodations.

- Over forty-seven percent (47%) of all responding Plans across all product lines have a process to track disability accommodations requests.

Disability Access Training (Questions 9-10)

In order to ensure access to health care for people with disabilities, it is important to promote appropriately accommodating and culturally competent services. For example, people with disabilities may require assistance from provider staff. But staff may not know that an individual has the right to request assistance or how to assist a person with a disability. This can cause frustration for both the person with a disability and the staff member. Questions inquiring about Plan staff and provider training sought information about:

- Various types of disabilities and chronic conditions

- Legal requirements presented in the Americans with Disabilities Act

- Definitions and concepts such as alternative formats, disability accommodations, medical equipment barriers, physical access barriers.

Some of the results from these questions included:
- Over fifty-seven percent (57%) of all responding Plans across all product lines have Disability Access Training for their Plan Member Services Staff.

- Over thirty-six percent (36%) of all responding Plans across all product lines have Disability Access Training for providers and their office staff.

Promoting Physical Access to Provider Offices (Questions 11-13)

Many people with disabilities do not obtain quality health care because of the lack of accessible health care facilities and/or medical equipment. As a result, some people with disabilities make primary and preventive health care services low priorities and pursue medical attention only for emergency or acute conditions. In addition, the lack of appropriate medical equipment can cause doctors to forgo procedures for people with disabilities they would ordinarily provide to other patients. Improving accessibility at health care facilities will encourage more individuals with disabilities to seek services, thus improving their general health. Questions in this section focused on Plans' policies, procedures, and training to assess providers' offices for physical access barriers including:

- Parking lots
- Path-of-travel into facility from parking lot and throughout facility
- Doors
- Exam and waiting rooms
- Medical Equipment (e.g. lift equipment, adjustable high/low exam tables, and wheelchair scales).

These questions were not intended to measure the level of accessibility of Plans' contracted providers. The goal was to determine if health plans made efforts to document the accessibility of providers' facilities and to share that information with health plan members. Some of the results include:

One-hundred percent (100%) of all responding Plans across all product lines have policies and procedures to perform a facility site review of contracted health care providers' offices for physical access barriers including:
- Parking lots
- Path-of-travel into facility from parking lot and throughout facility
- Doors
- Exam and waiting rooms
- Restrooms

- Over eighty percent (80%) of all responding Plans have policies and procedures to perform a facility site review of contracted health care providers' offices for medical equipment.

- Fifty-eight percent (58%) of all responding Plans across all product lines reported that Member Services or another department can provide upon request information on health care providers with accessible facilities.

- Only one (1) Plan reported having a Provider Directory that includes information on contracted providers with accessible facilities.

Non-Emergency Medical Transportation (Question 14-16)

The survey included questions regarding coverage and processes for requesting non-emergency transportation because transportation directly impacts whether or not people with disabilities can access care. Non-emergency medical transportation is needed when personal or public transportation is not available or when accessing available transportation is medically contraindicated. Even when public transportation is available through fixed-route public transit or paratransit, riders frequently experience delays, resulting in missed appointments. These reduce access to routine care and increase the rate of ER usage and hospitalization. Some of the results include:

- One hundred percent (100%) of all responding Plans that offer Medi-Cal and Medicare product lines provide non-emergency medical transportation as a covered benefit. They also have a process for members to request non-emergency medical transportation, including wheelchair-accessible van services.

Access to Health Plan Information (Questions 17-27)

The ADA's effective communication provision mandates covered entities to provide materials in alternative formats. These mandates require health care providers and health plans to communicate effectively with individuals who are deaf, hard-of-hearing, or have a speech, vision, or learning disability. Among other things, communication access involves providing content through means that are usable and understandable by individuals unable to use standard print materials because they cannot read, manipulate, or process print due to a visual, physical, or learning disability. Materials are provided in:

- Large print (14 point font or larger).
- Braille
- Audio formats (cassette, CD)
- Electronic formats (computer diskette, CD-ROM)

The goal is similar to that of services provided to people with limited English proficiency: to provide people with disabilities with easily understood, accurate health plan information in a manner equal to and as effective as information provided to other members. Some of the results from these questions include:

- One-hundred percent (100%) of all responding Plans have policies and procedures for the production of materials in large print.

- Thirty-eight percent (38%) of all responding Plans provide information and/or written materials to health care providers and their staff on how members can request Plan materials in alternative formats.

- Fifty-one percent (51%) of all responding Plans across all product lines provide disability access training to Member Service staff on how members can request Plan materials in alternative formats.

- One hundred percent (100%) of all responding Plans can mail materials in large print, Braille, and audiocassettes or CDs within 10 business days.

- One hundred percent (100%) of all responding Plans offer Provider Directories in large print and electronic formats on request.

- One hundred percent (100%) of all responding Plans with Medi-Cal and Healthy Families products offer their Member Handbooks/Evidence of Coverage (EOC)s in large print on request.

- One hundred percent (100%) of all responding Plans across all product lines offer their Member Handbooks/Evidence of Coverage (EOC)s in electronic format on request.
- One hundred percent (100%) of all responding Plans offer newsletters in large print and electronic formats on request.
- One hundred percent (100%) of all responding Plans offer grievance materials in large print and electronic formats on request.
- One hundred percent (100%) of all responding Plans that offer Medicare and Commercial product lines offer health education and preventive health materials in large print and electronic formats on request.

Question 27 Website Access

Websites should be accessible for all users, including people with disabilities who use a variety of assistive and adaptive software and alternative input devices to interact with their computers.

Many blind and visually impaired users employ screen reader software that reads the content of a page to the users. People with hearing impairments rely on captioning as an alternate to audio content. Those with dexterity impairments will employ a variety of adaptive keyboards and input devices.

The world wide web consortium (http://www.w3.org/) established the web accessibility initiative (http://www.w3.org/WAI/) to provide standards for accessible website design. Section 508 of the assistive technology act builds upon those standards for websites and electronic business conducted on government websites. Many state and local governments have adopted the section 508 standards for their sites and those of organizations, agencies and companies that do business with them.

The following were items discussed in the survey in an effort to determine the accessibility of health plans' websites including:

- Frames: Use the noframes element and meaningful titles; *Tables:* Make line-by-line reading sensible, etc.
- Complex graphics that convey important information (charts, graphs, illustrations) should be linked to detail descriptions (longdesc) that provide the same information for blind users.
- Audio/video content should be open captioned for hearing impaired users
- All non text elements should have alt tags providing description of the graphic's content or purpose

- Scripts, applets, & plug-ins: Provide alternative content in case active features are inaccessible or unsupported

- Images & animations: Use the alt tags to describe the function of each visual.

- Image maps: Use the client-side map and text for hotspots.

Additional items to consider where evaluating the accessibility of websites include:

- Text and background colors should provide good contract for people with low visions.
- Fonts should be easy to read, san-serif are preferable
- All pages should have a skip navigation link to enable blind users with screen readers to go directly to the body text on every page.

It is difficult to interpreter the results of this question because limitations in the online survey did not allow plans to indicate that they did not have a particular feature on their website. The results only indicate the number Plans that reported they were in compliance with a particular area but does not necessarily reflect the accessibility of a Plan's websites.

Images & Animations

- Six (6) Plans offering a **Medi-Cal** product.
- Six (6) Plans offering a **Healthy Families** product.
- Four (4) Plans offering a **Medicare** product.
- Four (4) Plans offering a **Commercial** product

Image Maps

- Six (6) Plans offering a **Medi-Cal** product.
- Six (6) Plans offering a **Healthy Families** product.
- Four (4) Plans offering a **Medicare** product.
- Four (4) Plans offering a **Commercial** product

Multimedia

- Three (3) Plans offering a **Medi-Cal** product.
- Three (3) Plans offering a **Healthy Families** product.

- Three (3) Plans offering a **Medicare** product.
- Three (3) Plans offering a **Commercial** product

Graphs & Charts

- Four (4) Plans offering a **Medi-Cal** product.
- Four (4) Plans offering a **Healthy Families** product.
- Four (4) Plans offering a **Medicare** product.
- Four (4) Plans offering a **Commercial** product

Tables

- Seven (7) Plans offering a **Medi-Cal** product.
- Seven (7) Plans offering a **Healthy Families** product.
- Five (5) Plans offering a **Medicare** product.
- Five (5) Plans offering a **Commercial** product

Scripts, Applets & Plug-ins

- Two (2) Plans offering a **Medi-Cal** product.
- Two (2) Plans offering a **Healthy Families** product.
- Two (2) Plans offering a **Medicare** product.
- Three (3) Plans offering a **Commercial** product

Frames

- Two (3) Plans offering a **Medi-Cal** product.
- Two (3) Plans offering a **Healthy Families** product.
- Four (4) Plans offering a **Medicare** product.
- Four (4) Plans offering a **Commercial** product

General Recommendations

Create a disability community advisory committee

OPA should create a Disability Committee to advise OPA on health care access for people with disabilities including compliance with Federal and State disability laws and regulations. The members should be drawn from organizations serving people with disabilities and from the general public who have an interest in, and knowledge of disability and health care delivery issues.

Conduct focus groups

Because examining health care service delivery for consumers with disabilities is a new initiative for OPA, the agency should conduct focus groups to obtain consumer input. It should seek input from them as to what they would like/need to know about their HMO. It should also inquire about the formats through which consumers with disabilities would prefer to receive this information.

Incorporate questions about alternative formats into existing cultural and linguistic survey

At present, OPA annually sends Health Plans an extensive sixty-three (63) question survey regarding cultural and language services. A number of those questions already address communication access issues for deaf or hard of hearing individuals. Other questions seek information about Plans' printed materials in languages other than English. Those latter questions should also seek information about the extent to which Plans make materials available in alternative formats (large print, audio, Braille, and electronic format). In responses to the pilot Disability survey, Plans reported that they wanted to be able to indicate when they delegate the provision of alternative formats to Plan Partners, Medical Groups, or Provider Offices. The existing Cultural and Language survey already responds to that concern.

Information on Evaluating Accessibility of Websites (1)

Websites should be accessible for all users, including people with disabilities who use a variety of assistive and adaptive software and alternative input devices to interact with their computers.

Many blind and visually impaired users employ screen reader software that reads the content of a page to the users. People with hearing impairments rely on captioning as an alternate to audio content. Those with dexterity impairments will employ a variety of adaptive keyboards and input devices.

The world wide web consortium (http://www.w3.org/) established the web accessibility initiative (http://www.w3.org/WAI/) to provide standards for accessible website design. Section 508 of the assistive technology act builds upon those standards for websites and electronic business conducted on government websites. Many state and local governments have adopted the section 508 standards for their sites and those of organizations, agencies and companies that do business with them.

Accessibility is a function of both the structure of a website and the way in which content is organized and presented. A validator can verify the syntax of your pages (are their alt tags for photos and graphics? Are tables properly labeled? Are there skip navigation links?), however, that correct syntax does not guarantee that a document will be accessible).This represents only a small portion (20-25%) of a site's accessibility.

Some examples of automatic validators include:

•   An automated accessibility validation tool such as Bobby (refer to [BOBBY]).
•   An HTML validation service such as the W3C HTML Validation Service (refer to [HTMLVAL]).
•   A style sheets validation service such as the W3C CSS Validation Service (refer to [CSSVAL]).

---

1 For more information on website accessibility guidelines and standards see:

•   Section 508 http://www.access-board.gov/508.htm.
•   Web Content Accessibility Guidelines 1.0, http://www.w3.org/TR/WCAG10/.
•   Web Content Accessibility Guidelines 2.0 http://www.w3.org/TR/WCAG20/.

Sites should also be tested by consumers using screen readers and other adaptive technologies to determine if people with disabilities will be able to navigate the site, locate and understand the information on it.

Examples of Items to consider for accessibility:

•	Complex graphics that convey important information (charts, graphs, illustrations) should be linked to detail descriptions (longdesc) that provide the same information for blind users.

•	Audio/video content should be open captioned for hearing impaired users

•	Text and background colors should provide good contract for people with low visions.

•	Fonts should be easy to read, san-serif are preferable

•	All pages should have a skip navigation link to enable blind users with screen readers to go directly to the body text on every page.

•	All non text elements should have alt tags providing description of the graphic's content or purpose

Examples of tools that assist with evaluating the accessibility of websites include:

Commercial Software tools

- Lift http://usablenet.com
- Ramp Ascend http://deque.com
- InFocus http://ssbtechnologies.com

Free Tools

- WebExact http://www.webxact.com/
- The Wave http://www.wave.webaim.org
- A-prompt http://aprompt.snow.utoronto.ca/

Recommendation

Incorporate accessible website evaluation into the existing Cultural and Language survey

The existing OPA Cultural and Linguistic survey includes questions addressing the linguistic accessibility of California Health Plans' websites (15-17). OPA should incorporate a question that broadly addresses the disability-related accessibility of those websites.   For example:

Has the Plan's website been assessed for disability-related access through an online web checker such as webxact (often referred to as Bobby Compliance) available for free at: http://webxact.watchfire.com/?

Utilize a different online survey tool

To improve the process by which plans report data, OPA utilized an online reporting system called Zoomerang (see http://www.zoomerang.com). The system greatly improved the efficiency of data analysis. However, the online system presented several challenges including:

- limitations in the visual layout for multi-part questions
- limitations in the ability to navigate the questions
- limitations in the ability to print responses when submitted
- limited space to make comments
- limitations in changing responses once submitted.

Despite these challenges, OPA should consider using an online reporting system in the future. But it should explore other survey tools that allow greater flexibility in the design, deployment, and analysis of survey data.

Policy Challenges and Recommendations

Responsibility for Accommodations

One of the greatest challenges in getting Health Plans to respond to the pilot survey was concern over how a Plan's responses might impact its liability if it does not as yet provide full access to health care services. As a result, considerable debate focused on where the responsibility ultimately should lie for ensuring access to health care services for people with disabilities. Some Health Plans declared that because services are delegated directly to Plan Partners (other health plans), medical groups, hospitals, and individual health providers OPA should target those entities for assessment. It is true that individual providers, medical groups, and hospitals are obligated to comply with federal and state laws that ensure the rights of people with disabilities. But managed care plans are required to ensure not only that the services they provide directly comply with the law, but also that services provided by contracted entities as a result of the contracted relationship are accessible to the greatest extent possible. (See appendices, *Disability related Federal and State laws*) [2]

Recommendation

1. Develop an educational brief for health plans and consumers with disabilities discussing consumers' rights as defined under the ADA and California Civil Codes and regulations to access healthcare services.

2. Offer training to DMHC agency officials, health plans, individual providers, medical groups, and hospitals regarding obligations under State and Federal disability rights laws.

---

2 *Zamora-Quezada v. Health Texas Medical Group of San Antonio*, 34 F.Supp.2d 433 (W.D. Tex. 1998)(denying defendant's motion for summary judgment because of fact question as to whether the HMOs regulated health care decisions made by the medical group, including referrals and admissions, and attempted to monitor and influence physicians' utilization patterns.); *Woolfolk v. Duncan,* 872 F.Supp. 1381 (E.D. Pa. 1995)(holding that where MCO has right and authority to interfere with and control a provider's treatment of enrollees, there is a genuine issue of material fact as to whether MCO is vicariously liable for provider's conduct under Title III of the ADA and Section 504.)

Physical Access Barriers

Despite the legal obligation to comply with the ADA no one organization in California or nationally is specifically monitoring, tracking, and providing consumers with information on the physical accessibility of licensed health care provider facilities. The vast number of health care provider groups, individual health care providers, and other health care facilities such as hospitals and imaging facilities makes it difficult for a single agency to implement a comprehensive assessment and information dissemination program usable by consumers and payers. (3)

Recommendation

1. OPA should explore opportunities to engage a broad group of stakeholders to facilitate a standardized approach for assessment and dissemination of information regarding the accessibility of individual health care provider facilities and other health care institutions, such as hospitals, imaging facilities, and laboratories.

2. OPA in collaboration with a Disability Advisory Committee should explore possible involvement with the Industry Collaboration Effort (ICE), a volunteer, multi-disciplinary team of providers, health plans, associations, state and federal agencies, and accrediting bodies working to improve health care regulatory compliance. For more information see, http://www.iceforhealth.org/home.asp ICE has a California Shared Commercial and Medicare Facility Site Review Survey that resulted from a statewide, multi-stakeholder effort to standardize and simplify the credentialing office review process. Disability-related physical access questions could be incorporated into the existing FSR. This would create a uniform assessment and serve as a mechanism to provide OPA with information regarding the physical accessibility of providers within Commercial and Medicare plans.

---

3 The regulations implementing the ADA include a broad set of building design specifications for new construction, additions, and remodeling: the Americans with Disabilities Act Standards for Accessible Design. California complies with these regulations through the California Building Standards Code, Title 24. The Division of the State Architect, Access Compliance (DSA-AC), promulgates building regulations for making buildings, structures, sidewalks, curbs, and related facilities accessible to and usable by persons with disabilities. Access compliance regulations apply to:
1 Publicly funded buildings, structures, sidewalks, curbs, and related facilities,
2. Privately funded public accommodations and commercial facilities, and
3. Public housing and private housing available for public use statewide

3. OPA should meet with Department of Health Services to determine approaches they are taking to amend the existing health plan FSR requirements to include more comprehensive disability-related physical access guidelines. This may provide OPA with information regarding the physical accessibility of contracted providers within Medi-Cal health plans.

Quality of Care Measures [4],[5],[6]

OPA's report card is a mechanism for consumers to evaluate the quality of health care services delivered by California Health Plans. Quality is defined in various ways, depending on consumers' needs. The Institute of Medicine (IOM) defines quality as the degree to which health services increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Quality may also be seen as the degree to which actions taken by a Health Plan and its contracted entities maximize the probability of beneficial health outcomes for health plan members and minimize their risk of developing a primary disease or secondary condition. Quality can be evaluated through several dimensions, including:

1. Quality of resources (e.g. health providers facilities, scope of covered benefits)

2. Quality of service delivery (e.g. use of appropriate procedures/treatments for a given condition, timeliness of care, efficiency of health plan procedures)

3. Quality of outcome resulting from service (e.g. actual improvement in condition, reduction of risk of developing secondary conditions, reduction of harmful effects from poor health behaviors).

The OPA pilot survey documents the quality of health plan resources and service delivery in terms of the accessibility of health plans' services, facilities, and materials. Measures such as these are designed to enable individuals with disabilities to determine how effectively they can access various components of the care delivery system. But the measures do not document one critical component: how a Plan's delivery of services actually affects members' health. Evaluations of health care quality are increasingly grounded in clinical performance measures [also called Health Plan Employer Data and Information Set (HEDIS) measures], and/or they are measured through consumer responses to satisfaction surveys [also called Consumer Assessment of Health Plans (CAHPS)]. Private sector quality monitoring organizations and state and federal regulators have selected these measures in order to compare clinical outcomes across managed care organizations.

---

[4] M. Mastal, and S, Palsbo, *Measuring the Effectiveness of Managed Care for Adults with Disabiliti*es. Centers for Health Care Strategies, December 2005.

[5] S. Palsbo, P. Beatty, P. Parker, C. Duff. *Designing a Program Evaluation for a Multi-Organizational Intervention: The Minnesota Disability Health Options Project,* Center for Health Care Strategies, January 2004.

[6] S. Sofaer, S.F. Woolley, K.A. Kenny, B. Kreling, D. Mauery. A Meeting the Challenges of Serving People with Disabilities. A Resource Guide for Assessing the Performance on Managed Care Organizations.@ Report to ASPE. July 1998. http://aspe.hhs.gov/DALTCP/REPORT/RESOURCE.HTM

The HMO Report Card currently reports on results of CAHPS surveys and HEDIS measures targeting diseases and conditions such as high blood pressure, diabetes, and asthma. People with disabilities are at a greater risk for developing secondary conditions. Therefore clinical performance measures are a critical component in presenting information about quality care. A defined set of quality outcome measures for seniors and persons with disabilities does not exist nationally. However, a number of existing preventative care measures focusing on prevalent secondary conditions could be utilized. In addition, specialized health plans such as AXIS Healthcare in Minneapolis are using measures relevant to individuals with physical disabilities, particularly those with spinal cord injuries, such as the incidence of bowel impaction, urinary tract infections, and pressure sores.

Several challenges exist in developing quality measures related to people with disabilities for use within health plans and to make comparisons across plans. These include:

- A lack of access to accurate encounter data from the State of California, Centers for Medicaid and Medicare Services (CMS), and among the health plans themselves.

- Difficulties in defining the population or making statistical comparisons due to variations in diseases and conditions among seniors and persons with disabilities. This is particularly challenging when individuals do not have a Medi-Cal aid code.

- Members in commercial and government-based product lines differ in terms of socioeconomic factors such as family income and education levels. This may impact individual health quality outcomes, thereby making comparisons among different health plan product lines difficult.

- Fluctuating eligibility for Medi-Cal and Healthy Families may lead to more breaks in coverage as compared to members in commercial plans. These gaps in coverage impact continuity of care and may affect health outcomes.

- Scope of benefits and services vary from Plan to Plan and among individual Plan's product lines.

- The financial and technological resources necessary to collect, clean, and evaluate data hinder statewide implementation of quality measures.

Recommendation:

1. OPA should work with the California Endowment or California Health Care Foundation to identify and allocate funding to pilot quality measures among a group of California health plans to promote the management of secondary conditions among targeted populations of people with disabilities.

2. Several Health Plans including CalOptima and Inland Empire Health Plan (IEHP) currently utilize CAHPS surveys targeted to individuals with disabilities. OPA should explore approaches to create incentives for other California Health Plans to utilize this survey as part of their annual consumer satisfaction evaluations.